

**APPLICANT CHECKLIST**

Please note: You are required to bring your **passport or UK birth certificate** for identification purposes

**Please send copies of the following documents with the completed application** (failure to do so will result in application not being processed). Bring originals documents with you to the interview:

	Admin sign	RM sign
▪ Passport or UK birth certificate	. ....	.....
▪ Proof of permission to work in the UK (valid visa)	. ....	.....
▪ Proof of Address e.g. utility bill <b>(Must not be more than 3 months old)</b> .	. ....	.....
▪ <b>3</b> passport size photographs <b>(write your name on back of every photograph)</b>	. ....	.....
▪ <b>Relevant original</b> certificates or diplomas, healthcare certificates	. ....	.....
▪ Bank/building society details	. ....	.....
▪ CRB Enhanced Disclosure <b>(cash payment of £55.00 to process CRB)</b>	. ....	.....
▪ NI Card / P45 / P60	. ....	.....
▪ Proof of vaccination <b>(Hepatitis B, Hepatitis C, Varicella, Measles, Mumps, HIV, Rubella, Tetanus, TB)</b>	. ....	.....
▪ NMC Pin with the statement of Entry <b>(registered nurses)</b>	. ....	.....
▪ NVQ Qualification Level 2/ 3 / 4 <b>(support workers)</b>	. ....	.....
▪ Current CV <b>(A full employment history, together with a satisfactory written explanation of all gaps in employment)</b> . Email to <a href="mailto:info@rainbowmedicalservices.com">info@rainbowmedicalservices.com</a>	. ....	.....

**Office Use Only:**

- Written Test: \_\_\_\_\_
- ID badge issued: \_\_\_\_\_
- Starter Form: \_\_\_\_\_
- GSCC Code, UKHCA Code, Contract, Staff Handbook issued: \_\_\_\_\_
- Reference 1 Sent: \_\_\_\_\_ Received: \_\_\_\_\_
- Reference 2 Sent: \_\_\_\_\_ Received: \_\_\_\_\_
- Reference 3 Sent: \_\_\_\_\_ Received: \_\_\_\_\_

# APPLICATION FORM

ALL APPLICANTS MUST ANSWER ALL QUESTIONS ON THIS FORM IN BLACK INK. PLEASE COMPLETE IN BLOCK CAPITALS.

## PERSONAL DETAILS

MR/MRS/MISS/MS	SURNAME	FORENAMES
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ANY OTHER NAMES:

NMC PIN  POSITION APPLIED FOR:   
HCA/RGN/RMN  
Other:.....

PERMANENT ADDRESS:

TELEPHONE (HOME):

TELEPHONE (MOBILE):

DATE OF BIRTH:  N.I number:

NATIONALITY: ..... MARITAL STATUS: .....

DATE OF ENTRY INTO THE UK: ..... DO YOU HAVE PERMISSION TO WORK? .....

PLEASE STATE WHICH TYPE OF VISA YOU HAVE: .....

**NEXT OF KIN:**

NAME:	RELATIONSHIP:
ADDRESS:	TELEPHONE:

FULL TIME  PART TIME

**EMPLOYMENT HISTORY (please start with your most recent employment)**

PLEASE GIVE DETAILS OF ALL PREVIOUS EMPLOYMENT. PLEASE CONTINUE ON A SEPARATE SHEET IF NECESSARY.

<p>DATES OF EMPLOYMENT: From:                      to:</p> <p>POSITION HELD:</p> <p>NAME &amp; ADDRESS OF EMPLOYER:</p> <p>REASON FOR LEAVING:</p>	<p>DUTIES AND RESPONSIBILITIES:</p> <p>SALARY:</p>
<p>DATE OF EMPLOYMENT: From:                      to:</p> <p>POSITION HELD:</p> <p>NAME AND ADDRESS OF EMPLOYER:</p> <p>REASON FOR LEAVING</p>	<p>DUTIES AND RESPONSIBILITIES</p> <p>SALARY:</p>
<p>DATE OF EMPLOYMENT: From:                      to:</p> <p>POSITION HELD:</p> <p>NAME AND ADDRESS OF EMPLOYER:</p> <p>REASON FOR LEAVING</p>	<p>DUTIES AND RESPONSIBILITIES</p> <p>SALARY:</p>

**FURTHER EDUCATION & TRAINING:**

<u>ORGANIZING BODY</u>	<u>FROM</u>	<u>TO</u>	<u>QUALIFICATION OBTAINED/EXPECTED</u>

PLEASE ACCOUNT FOR ANY GAPS IN EMPLOYMENT (FOR EXAMPLE UNEMPLOYMENT, VOLUNTARY WORK, RAISING A FAMILY, TRAVELLING, ETC)

FROM	TO	REASON

**SUITABILITY FOR THE POST APPLIED FOR:**

Please state how your skills and experience meet the person specification. Continue on an additional sheet if required.



**ADDRESSES:**

I have lived at my present address since:.....

**Previous addresses:**  
 (Must cover previous five years - **(to include month and year)** – use separate sheet if required:

**OTHER INFORMATION:**

Place of birth:

Your maiden name:

Your height:

Colour of your eyes:

Do you have any other identifying particulars? **(Please state them)**

**CODE OF CONDUCT**

I have read and understood the Terms and conditions of employment and have been issued with a copy. I agree to adhere to the terms at all times.

Signed:..... Date:.....

**WORKING TIME REGULATIONS**

Please declare other work commitments and the average number of hours worked per week.

Signed:..... Weekly hours worked:.....

**Working Time Regulations (opt-out agreement)**

I, \_\_\_\_\_ agree that I (am permitted to work) may work for more than an average of 48 hours a week. If I change my mind, I will give Rainbow up to one month notice in writing to end this agreement.

Signed:..... Date:.....

**CONFIDENTIALITY AGREEMENT**

I agree that during the time I am engaged by Rainbow Medical Services Ltd to work in any capacity:

- a. I will not disclose to any person, any information obtained whilst attending an assignment.
- b. I will hold in trust and confidence for Rainbow Medical Services Ltd, all such information, and never use it other than for the benefit of Rainbow Medical Services Ltd.

Signed: ..... Date: .....

**DISCIPLINARY ACTION**

Have you ever been the subject of disciplinary action? YES  NO

If yes please give details:

**DATA PROTECTION STATEMENT:**

Any documentation submitted as part of your application will be retained by Human Resources for the duration of the recruitment process and used for recruitment only. Your documentation will be kept securely for a specified period of time before being destroyed. Data may only be processed with the consent of the person whose data is held. Therefore if they have not consented to their personal details being passed to a third party this may constitute a breach of the Data Protection Act 1998.

**DECLARATION**

*(Providing any misleading or false information to support your application will disqualify you from appointment.)*

I hereby declare that I have understood and complied with the requirements laid down in the application and I agree that the information given on this form may be used for registered purposes under the Data Protection Act, 1984.

Signature of Applicant

Date:

.....

.....

**EQUAL OPPORTUNITIES POLICY**

Rainbow Medical Services Limited is committed to promoting Equal Opportunities. Our policy is to ensure that job applicants and employees receive equal treatment irrespective of their race, colour, gender, age or disablement. By completing all sections of this form you will help us to monitor the effectiveness of our Equal Opportunities policy. All information will be held in strictest confidence.

**EQUAL OPPORTUNITIES POLICY – MONITORING CHECKLIST**

For the sole purpose of monitoring our policy stated above, please complete the following:

**Gender:** Male  Female

**Nationality/Racial Origin:**

Asian <input type="checkbox"/>	Black <input type="checkbox"/>	White <input type="checkbox"/>
Pakistani <input type="checkbox"/>	African <input type="checkbox"/>	British <input type="checkbox"/>
Bangladeshi <input type="checkbox"/>	Caribbean <input type="checkbox"/>	European <input type="checkbox"/>
Indian <input type="checkbox"/>	British <input type="checkbox"/>	Other <input type="checkbox"/>
Other <input type="checkbox"/>	European <input type="checkbox"/>	
	Other <input type="checkbox"/>	

**Disability**

Do you consider yourself to have a disability which will affect your day-to-day work?

YES

NO

If yes, please give details:.....

How did you hear about us? .....

**OFFICE USE ONLY:**

Passport Seen YES

NO

Passport No:.....

Driver's Licence seen YES

NO

D/Licence No:.....

CRB number: .....

Issue Date.....

Level of written English: POOR

FAIR

GOOD

EXCELLENT

Level of spoken English: POOR

FAIR

GOOD

EXCELLENT

NI number confirmed: YES

NO

Relevant Right to Work documents seen: YES

NO

Details of documentation seen:.....  
.....  
.....  
.....

**VACCINATION CERTIFICATES/REPORTS FOR THE FOLLOWING:**

- o Hepatitis B
- o Hepatitis C
- o Measles
- o Mumps
- o Rubella
- o Varicella
- o TB
- o HIV

**CONFIDENTIAL HEALTH QUESTIONNAIRE**

Name of Candidate: .....

When did you last have a physical examination? .....

How many days have you lost due to illness in the last 2 years? .....

Are you currently suffering from, or suffered in the past from:

- |   | <b>YES</b> | <b>NO</b> |
|---|------------|-----------|
| 1. Any type of skin complaint?  | [ ]        | [ ]       |
| 2. Any type of allergy?   | [ ]        | [ ]       |
| 3. Back trouble?  | [ ]        | [ ]       |
| 4. Heart complaint?   | [ ]        | [ ]       |
| 5. Ulcer or stomach or duodenum or bowel disorder, dysentery, typhoid cholera or chronic diarrhoea? | [ ]        | [ ]       |
| 6. Mental or nervous breakdown?   | [ ]        | [ ]       |
| 7. Jaundice, hepatitis or liver disease?  | [ ]        | [ ]       |
| 8. Disorders of the eye, ears or nose?  | [ ]        | [ ]       |
| 9. Have you ever been informed that you are a carrier of salmonella?                                | [ ]        | [ ]       |
| 10. Asthma, bronchitis, persistent cough, coughing up blood or other chest complaints?              | [ ]        | [ ]       |
| 11. Blackouts, migraine, epilepsy, fits, fainting attacks or disease of the nervous system?         | [ ]        | [ ]       |
| 12. Depression, mental illness or nervous breakdown?  | [ ]        | [ ]       |
| 13. Drug and alcohol abuse?   | [ ]        | [ ]       |
| 14. Are you at present receiving any medical treatment? If so, please give details.                 | [ ]        | [ ]       |

.....

Name and address of your General Practitioner: .....

..... Telephone number: .....

Signature of Candidate..... Date: .....

**DIRECT CREDIT TO YOUR BANK OR BUILDING SOCIETY ACCOUNT**

**YOUR NAME:** .....

**BANK ACCOUNT DETAILS**

NAME OF BANK:.....

BRANCH:.....

SORT CODE:.....

CURRENT ACCOUNT NUMBER:.....

SAVINGS ACCOUNT NUMBER:.....

**BUILDING SOCIETY ACCOUNT DETAILS**

NAME OF BUILDING SOCIETY.....

BRANCH:.....

SORT CODE:.....

CURRENT ACCOUNT NUMBER:.....

SAVINGS ACCOUNT NUMBER:.....

BUILDING SOCIETY ROLL NUMBER:.....